Perspectives on the experience of being physically restrained: an integrative review of the qualitative literature

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CRD summary
The author concluded that limited evidence suggested that physically restraining patients could have serious implications for patients and their nurses. Lack of clarity in the review process, and the possibility of missed studies in the search, mean that the reliability of the findings is unclear.

Authors' objectives
To evaluate patients' perspectives on being physically restrained.

Searching
CINAHL, PubMed, and PsycINFO were searched for peer-reviewed English-language articles, published between 1966 and 2009. Key search terms were reported. Reference lists were screened to identify further articles.

Study selection
Eligible for inclusion were qualitative studies (or studies with a qualitative component) of physical restraint (broadly defined as physically restricted movement), conducted in any setting and involving any patient.

The included studies were conducted in the UK, USA, Canada, China, or Norway. Clinical settings varied, including in-patient psychiatric; in-patient medical; medical surgical intensive care; and in-patient residential for people with development or intellectual disabilities. The age of patients varied from teenagers to those aged 90 years or older. Physical restraint mechanisms included extremity or vest restraints, physical holding without any device, and other interventions more loosely described as manual or physical.

The author did not state how many reviewers selected the studies for inclusion.

Assessment of study quality
The assessment of study quality covered vivid description, methodological congruence, heuristic relevance, analytic precision, and connection to theory. Study quality was graded to levels of evidence (QI for strong, to QIII for weak), using the tool constructed by Cesario and colleagues, in 2002.

The author did not state how many reviewers assessed quality.

Data extraction
The author reported a coding process that involved reading and re-reading of the data; note taking; and organising groups of text with similar content and meaning. A continuous process of categorising and summarising was carried out in preparation for the synthesis.

The author did not state how many reviewers coded the data.

Methods of synthesis
A thematic synthesis was presented. Participant quotes were used to illustrate the points.

Results of the review
Twelve studies were included in the review, with approximately 239 patients. Most studies did not describe the method of analysis used to arrive at the authors' conclusion, and most did not verify their findings with patients. Five studies were considered to be level QI (strong) evidence, and seven were level QII (medium) evidence.

Four themes were identified, relating to patients' perspectives on being physically restrained.

Negative psychological impact: Participants' response to physical restraint frequently included anger, fear, humiliation,
demoralisation, dehumanisation, degradation, powerlessness, distress, embarrassment, and feeling that their integrity had been violated.

Re-traumatisation: Participants associated physical restraint with victimisation and which brought back traumatic memories of violent attacks against them.

Perceptions of unethical practices: Physical restraint by clinicians was considered by patients to be punitive, abusive, or unethical.

Broken spirit: Physical restraint was associated with feelings of helplessness, hopelessness, and a sense of broken spirit.

Authors' conclusions
Limited evidence suggested that physically restraining patients could have serious implications for patients and their nurses.

CRD commentary
The review question was clear. The inclusion criteria were broadly defined, identifying a wide variety of studies. Several relevant data sources were searched, but there were publication and language restrictions, meaning that relevant studies may have been overlooked. The number of reviewers involved in the process was not reported, but the review was conducted by one nurse, and the potential for error and bias cannot be ruled out. Relevant quality assessment criteria for qualitative studies were applied. The coding process and method of synthesis were explained; the findings were clearly presented; and higher quality studies were identified. The full findings of the quality assessment were not reported, making it difficult to verify the author's classification of level of evidence.

The author made a cautious conclusion, which seems justified for the data presented, but uncertainty in the conduct of the review and the potential for missed studies, mean that the overall reliability of the review is unclear.

Implications of the review for practice and research
Practice: The author stated that physical restraint should be used with caution, being aware of its potential psychological impact on patients. Alternatives to physical restraint, such as de-escalation, should be considered.

Research: The author stated that research should focus on the implications of physical restraint on the patient-nurse relationship, and should consider other settings, such as the emergency department or acute psychiatry. Quantitative studies were recommended to evaluate the efficacy of restraint alternatives.

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